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Dignity is the method: ethnic minority mental health, structural harm, and the constellation model

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Abstract

Dignity is not a metaphor. It is a method and mechanism. In this article, the authors critically explore the concepts of tolerance, respect, and dignity through the lens of ethnic minority mental health, arguing that dignity must become a diagnostic principle within psychiatry. Drawing on recent findings in stress biology, social psychology, and global policy, it presents how dignity violations, ranging from subtle exclusions to structural violence, leave biological, psychological, and cultural impacts. At the cellular level, chronic stress linked to exclusion activates inflammatory pathways, shortens telomeres, and predicts psychiatric morbidity. At the meso-social level, cultural othering, forced migration, and political authoritarianism incite stigma and internalized shame. At the macro-structural level, austerity, hostile immigration laws, and regressive policies erode collective mental well-being. The article further explores the concept of double jeopardy, where ethnic minority status and psychiatric diagnosis intersect to multiply vulnerability, institutional mistrust, and diagnostic harm. We argue that dignity must be restored as a measurable outcome, not a rhetorical flourish. The proposed model of the "Dignity Constellation for Ethnic Minority Mental Heath" outlines a multilevel framework where dignity injuries can be identified and repaired, from clinical to legislative spaces.

Keywords: *minority mental health, dignity, policy, ethnicity*

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1. Introduction

Tolerance, respect, and dignity are concepts deeply intertwined, each carrying distinctive implications for how we interact with and perceive others, especially in the context of mental health. This becomes even more relevant regarding the mental health of ethnic or any other minority groups at the individual, familial, and community levels. Although tolerance in contemporary culture is subscribed to a progressive stance, it inherently positions one party, the tolerator, as holding power or moral superiority, implicitly delineating a boundary between what is considered normative and what is perceived as deviant or requiring acceptance. In contrast, respect, derived from the Latin "respicere" meaning "to look again" or "to consider closely", signifies an active and intentional acknowledgment of the other. To respect is to engage, value consciously, and genuinely attempt to understand another's perspectives and feelings. Thus, indifference or superficial dismissal fundamentally contradicts the spirit of respect. Dignity encompasses a person's inherent worth and is the cornerstone of human interaction, particularly critical in mental healthcare. In therapeutic settings, mutual respect is important from the concepts of "unconditional positive regard", but if there are difficulties in acknowledging similarities and differences, mutual suspicion may take hold. Respect directly upholds and reinforces dignity, from simple acts of politeness to deeply valuing individuals' lived experiences, emotional states, and cultural narratives. Dignity, therefore, is not merely an ethical ideal, it is a mechanism with measurable biopsychosocioanthropological effects and a method for clinical diagnosis and systemic intervention. This paper argues that dignity should serve as a central organizing principle in addressing mental health inequities, especially for ethnic and cultural minorities. We propose that dignity violations act as stressors across cellular, individual, social, and policy levels and that restoring dignity across these domains should be a therapeutic and public health imperative.

Although the Universal Declaration of Human Rights (UDHR) enshrined dignity as a universal value affirming the right to a standard of living adequate for health and well-being, including medical care and social services, it remains an open question whether we have truly achieved this vision, particularly in mental health [1]. In its Diamond Jubilee year, the UDHR calls us not just to reflect but to act especially as political, cultural, and structural forces continue to challenge the dignity of marginalized populations.

This paper expands on concepts related to tolerance, respect, and dignity, integrating recent scholarly conversations and building a scaffold that spans biology, psychology, sociology, and policy. We end by proposing a model of "The Dignity Constellation for Minority Mental Health"—a multilevel framework designed to map where dignity is eroded and where targeted interventions can restore it. This model situates dignity harms across five levels, namely cellular, individual, interpersonal, community, and policy/societal levels, each with corresponding outcomes and practi-

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cal levers for repair. This framework is especially critical in the context of intersectionality, where mental illness and minority status combine in forms of double jeopardy. For the purposes of this paper, "ethnic minority mental health" refers to individuals and groups who face structural disadvantages based on ethnicity, culture, migration status, sexual orientation, or gender identity. While the primary focus is on ethnic minorities, we also consider how intersecting forms of marginalization such as those experienced by Lesbian, Gay, Bisexual, Transgender, and Queer plus (LGBTQ+) communities and refugees create layered dignity harms that impact mental health outcomes. This broader lens allows us to account for shared mechanisms of exclusion, stigma, and structural vulnerability across minority identities.

2. Micro-dignity: looking into the cellular level

2.1. Allostatic load—disrespect entering the bloodstream

Allostasis is a bodily process through which the body maintains homeostasis in response to stress. Unsurprisingly, when stress is chronic, the adaptive system becomes dysregulated, resulting in "wear and tear" on biological systems, known as allostatic load [2]. Stress biology has mapped how social injuries become cellular scars, and this is particularly important in the context of minority stress. Repeated humiliation, exclusion, or coercion is an example of violations of dignity at the core level, which activate the hypothalamic–pituitary–adrenal (HPA) axis, maintain cortisol surges, and leave the immune system in a low-grade inflammatory state. Ravi et al. [3] showed that chronic perceived stress predicts elevations in C-reactive protein (CRP) and pro-inflammatory cytokines such as interleukin-6 and tumour necrosis factor-α, as well as other biological signatures strongly linked to depression and anxiety. Chronic stress not only fuels mental illness but also drives physical disease through immunological dysregulation—increasing the risk of hypertension, cardiovascular disease, diabetes, and autoimmune conditions [4]. Minority groups, already facing barriers to healthcare access, experience these burdens more acutely. Structural inequalities persist across both psychiatric and general medical care, and mounting evidence shows that extreme stress leaves epigenetic marks. These findings echo Jacobson's notion of dignity of self [5].

This framework refers to a person's internal sense of worth, integrity, and self-respect, particularly how individuals experience and perceive themselves to how others treat them in a society. For people from ethnic minorities living with chronic mental health conditions, this has a broader implication as race and ethnicity, culture, and mental illness intersect to shape their perceptions about themselves. Hence, it is imperative to be intersectional because cultural misrecognition and institutional racism can keep these individuals in the bubble of allostatic load.

2.2. Social defeat and neuro-inflammation

Models of "repeated social defeat" (RSD) produce microglial activation and anxiety-like behaviours that persist long after the initial insult at the cellular level [6]. The model illustrates neuroimmune interaction that shows that monopolization by an aggressive conspecific is not stressful but a biologically encoded message of low rank and thus an insult to dignity. Translational studies echo this as well. Social defeat predicts psychotic experiences such as perceptual distortions, paranoid ideation, or delusional thinking via aberrant salience networks, a neurobiological model of psychosis that explains how irrelevant stimuli are perceived as significant [7]. Humiliation is thus not metaphorical but molecular. This is further significant for individuals already marginalized by race, culture, chronic mental health conditions, or immigration status. This further activates chronic neuroinflammatory pathways reinforcing psychiatric vulnerability.

2.3. Epigenetic weathering and telomere attrition

Discrimination leaves a genomic shadow. Decades ago, a longitudinal relationship was established that showed the African–Caribbean migrant population was vulnerable to chronic mental health conditions [8]. A recent review linked racial trauma to accelerated epigenetic ageing, implicating methylation patterns on stress response genes [9]. These findings extend dignity downward to the genome, illustrating UDHR Article 25 in a microcosm, showing that persistence in indignity shortens life.

3. Meso-dignity: society, culture, and interpersonal worlds

3.1. Otherism—difference as dignity's raw material

Contemporary psychiatric culture often preaches "tolerance", but tolerance can be a loaded and asymmetrical gesture. Tolerance operates as a regulatory discourse granting conditional acceptance from a dominant group to a minoritized one—thereby reinforcing existing hierarchies [10]. In this sense, tolerance imagines unidirectional power flowing from the "normal" toward the "deviant", implicitly pathologizing differences rather than valuing them. Respect, by contrast, demands mutual recognition and ethical reciprocity. Within this framework, ethnic minorities are often positioned as "objects of tolerance" rather than full subjects of respect—permitted to exist within the system but only under terms defined by the dominant culture. This aligns with the logic of otherism, a colonial inheritance that ranks human difference in terms of value and proximity to dominant norms [11]. Ethnic minorities—particularly racialized groups such as Black, South Asian, and South Americans in the US—are often assigned a lower rung in this hierarchy, treated as peripheral or "less-than". This status is not merely symbolic. Being kept in this position of conditional inclusion or exclusion activates sustained stress responses, driving up cortisol levels and, over time, increasing vulnerability to depression, anxiety, and even psychosis [12]. These effects are compounded when political or media discourses validate such hierarchies, turning prejudice into policy or public sentiment into surveillance. Additionally, otherism, when validated by political or media discourse, can cause prejudice to escalate to harassment, assault, or hate crime. Otherism often starts with "they" and crystallizes into xenophobia, homophobia, transphobia, antisemitism, and islamophobia [11, 12]. Collectively, each incident reinforces fear, further eroding the dignity and mental health of targeted ethnic minorities.

3.2. Geopsychiatry—mapping distress onto displacement

At the end of 2024, a staggering 123 million people were forcibly displaced worldwide [13]. War, climate crisis, and forced migration now shape the mental health caseload, yet only 4% of UK psychiatric trainees report adequate instruction in geopolitical determinants [14]. Geopsychiatry demands curricula that track the multi-layered traumas of climate refugees, conflict survivors, or asylum seekers detoured into detention. This must be embedded within a broader shift in both undergraduate and postgraduate medical education. Training should go beyond the biomedical model to include humanities, public health, and medical anthropology, enabling a biopsychosocioanthropological approach that recognizes how biology, psychology, social structures, and cultural meaning interact in the development, perception, and treatment of illness. Hence, prevention must start early through education that cultivates mutual respect, cultural humility, and structural awareness, helping society recognize that dignity is not a clinical luxury but the foundation of health. The World Health Organization (WHO) warns that post-arrival stressors like family separation, insecure status, and hostile media can be as perilous as the original trauma [15]. Geopsychiatry information system (GIS) maps, asylum law, and climate displacement forecasts enable clinicians to document and help their ethnic minority patients navigate uncertain legal scenarios or situations.

3.3. Right-wing authoritarianism and stigma

Recent data show a clear pattern in a person's score on right-wing authoritarianism (RWA). RWA is a trait cluster characterized by strict obedience to authority, hostility toward out-groups, and a preference for social conformity—the higher the score, the more likely they are to judge people with mental illnesses such as schizophrenia, major depression, or alcohol-use disorder more harshly [16]. Authoritarian mindsets treat any deviation from the "approved" norm as a threat to group stability. Psychiatric symptoms, by definition, challenge expected behaviour, so individuals high in RWA reflexively label such patients as dangerous, weak, or morally defective. This results in external stigma, as people with high RWA scores are more likely to support and uphold harsher public attitudes, greater social rejection, and institutional policies that prioritize control over care for individuals living with mental illness. The other resultant is internalized stigma that corrodes self-dignity, amplifying shame, delaying help-seeking, and worsening prognosis. Hence, additional anti-stigma efforts like posters, hashtags, and wellness slogans barely dent the problem if they sidestep its political undercurrents. Unless clinicians, professional bodies, and public health leaders call out these narratives, clinicians will keep treating symptoms in the consulting room, while status-driven stigma spreads unchecked in society.

4. Macro-dignity: law, economics, and statecraft

While interpersonal and community dynamics shape the day-to-day experiences of dignity, structural forces operating at the level of law, economics, and governance exert a more ambient but equally powerful influence. For ethnic minorities, these macro-level conditions often create environments where dignity is either systematically undermined or selectively upheld. Economic austerity, punitive legislation, and policy neglect translate abstract values into tangible inequalities, causing disparities in access, quality, and outcomes of care. This next section on macro-dignity explores how dignity is shaped by systems that govern the societal distribution of resources, rights, and recognition.

4.1. Austerity as a dignity tax

Austerity policies worldwide have eroded mental and physical well-being, especially among marginalized groups. Movsisyan et al. [17] noted that the global post-2008 financial crisis highlights how fiscal consolidation deepened health inequities internationally. Additionally, it shows that austerity tends to worsen overall mental health disparities, particularly in contexts where public services are already fragile [17]. Empirical studies corroborate the following: in the UK, cuts to local council services—such as cultural, environmental, and planning support—were significantly associated with deteriorating mental health, especially in deprived areas [18]. More broadly, systematic reviews show that austerity-induced income stress, housing instability, and food insecurity profoundly undermine mental health across diverse income settings, with disproportionately severe effects for those already facing disadvantages [19, 20]. Taken together, the data confirm that austerity not only slashes budgets but multiplies stressors for vulnerable populations, disproportionately affecting ethnic minorities.

4.2. Legislative changes versus global backlash

From a clinical standpoint, the evolving legal context on both sides of the Channel will directly shape everyday decision-making. In England and Wales, the Mental Health Bill 2025 is expected to tighten criteria for compulsory admission, formalize advance choice documents (ACDs), and mandate culturally specific advocacy services [21]. If backed by proper funding and audited via dashboards that track detention rates and community treatment orders by ethnicity, these measures should reduce coercion, improve shared decision-making, and enhance therapeutic alliance, core components of dignified care. Meanwhile, the European Court of Justice's Advocate-General has deemed Hungary's ban on "LGBTQ content" incompatible with dignity and non-discrimination [22]. Similarly, across the Atlantic, in the United States, more than 750 state-level bills aiming to curb LGBTQ-inclusive curricula or restrict gender-affirming care were tabled during the 2025 legislative cycle, with 26 states already enforcing such bans, according to the American Civil Liberties Union [23]. In India, the Supreme Court's October 2023 ruling declined to recognize same-sex marriage, leaving queer couples without marital rights [24]. These rulings, although outside clinical settings, matter to psychiatrists across the world and reinforce the principle that a patient's identity must be respected in schools, media, and public life domains that heavily influence help-seeking, stigma, and treatment adherence. For clinicians, this inconsistency means patients may present with dignity injuries caused by the very systems that claim to defend them.

5. Double jeopardy

The intersection of minority status and psychiatric diagnosis combines a form of double jeopardy, which is a compounded

vulnerability where individuals face discrimination on multiple levels simultaneously [25]. Ethnic minorities, particularly those living with various mental health conditions, not only navigate the stigma attached to psychiatric labels but also bear the baggage of racialized surveillance, systemic neglect, and cultural misappropriation. For example, ethnic minority patients in the UK are more likely to be sectioned under the Mental Health Act and less likely to receive talking therapies [26]. Similarly, Black men with psychosis are unusually subjected to coercive interventions, with their emotional expression often read through the gaze of danger rather than distress. Hence, cultural idioms of distress are often translated into pathology. This double jeopardy is not an accidental phenomenon but a result of systemic failure that account for how difference compounds existing risk.

6. The dignity constellation for minority mental health: a multi-level model

In light of the multiple, intersecting stressors faced by ethnic, cultural, sexual, and migration minorities, the Dignity Constellation offers a reference model to identify where dignity is eroded and where targeted interventions may restore it (**Table 1**). Each layer aligns with a biopsychosocioanthropological framework and offers clinically and systemically relevant entry points for action.

7. Discussion

Culturally responsive care already shows promise. Services for psychological therapies in England have piloted culturally adapted cognitive behavioural therapy (CBT) programmes for South Asian communities, showing improved engagement and outcomes [27]. In Canada, some clinics have begun employing ethno-racial matching and trauma-informed interpreters to reduce diagnostic error [28]. These initiatives suggest that having ethnically concordant clinicians, interpreters, and community liaisons can improve timeliness, adherence, and cultural safety in mental healthcare. However, these remain exceptions rather than the norm, and access to such services remains uneven globally.

Within this landscape, the Dignity Constellation offers a practical framework. This prompts clinicians and policymakers to treat dignity deficits as seriously as symptoms. In routine practice, the model can be used for

- Formulation: The model can be used to integrate dignity-related factors into biopsychosocial formulations by identifying experiences of coercion, exclusion, or systemic neglect across any layer of the constellation.
- Assessment: The mode can be used to include dignity harms in patient histories, for example, asking whether patients have felt dismissed, humiliated, or treated unfairly by services or institutions.
- Clinical supervision and MDT meetings: The model can be used to examine how team routines and service structures may perpetuate or repair dignity injuries and adjust pathways accordingly.
- Policy advocacy: The model can be used to audit structural dignity deficits such as unequal access, coercive practices, or culturally unsafe care, as well as resources for corrective action.

Table 1 • Dignity constellation for minority mental health.

Layer	Typology	Examples of dignity violations	Biomarkers/outcomes	Corrective levers
Cellular	Micro (Biological)	Chronic stress, racial trauma, neuroinflammatory burden	Cortisol dysregulation, microglial priming, CRP*, telomere attrition	Anti-inflammatory lifestyle, epigenetic research, trauma-informed care
Individual	Micro (Psychological)	Coercive restraint, diagnostic overshadowing, racialized diagnosis	Learned helplessness, internalized stigma, treatment avoidance	Advance choice documents, culturally sensitive care pathways
Interpersonal	Meso (Relational)	Bullying, misgendering, microaggressions, racial profiling	Social defeat stress, attachment disruption, help-seeking delays	Peer support, allyship training, therapeutic alliance development
Community	Meso (Social/ Environmental)	Food deserts, unsafe housing, under-resourced schools, hate speech	Area-level CMD** prevalence, suicide clusters, health disparities	Place-based infrastructure, services, and systems reform, inclusive journalism standards, community anchors
Policy/Societal	Macro (Structural)	Austerity, anti-LGBTQ+ legislation, and hostile immigration policies	Structural stigma, population CMD** burden, disengagement from care	Rights-based legislation, equity audits, diverse representation in decision-making

*CRP = C-reactive protein; **CMD: common mental disorders.

Rather than locating pathology solely within the individual, the Dignity Constellation shifts the focus toward context-sensitive care by diagnosing not only symptoms but the dignity injuries that exacerbate or generate them. In this way, it becomes a method of clinical seeing, offering a structured lens for both diagnosis and redress.

8. Conclusions

Mental healthcare must invest in benevolent tolerance and replace it with a radical politics of respect. Dignity is not an idealistic concept but a biological, social, psychological, and legal imperative. As demonstrated in the article, insults to dignity leave scars in the bloodstream, the community, and the policy ledger. Psychiatry, to remain ethical and effective, must elevate dignity as a diagnostic principle and therapeutic goal.

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Conflict of interest

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